MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

April 14, 2010
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, April 14, 2010 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Doug Berger, Jim Forrester, Charlie Dannelly, and William Purcell, and Representatives Martha Alexander, Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, Carolyn Justus, and Fred Steen. Advisory members Senator Larry Shaw and Representative William Brisson were present. Also in attendance were Senator John Snow and Representative Pat Hurley.

Lisa Hollowell, Shawn Parker, Joyce Jones, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff member Ben Popkin listened to the meeting via real-time streaming audio through the NCGA intranet. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the March 10, 2010 meeting. The motion was made by Representative England and the minutes were approved.

Lanier Cansler, Secretary of the Department of Health and Human Services (DHHS), advised that this will be a particularly difficult time with difficult decisions due to the budget shortfall. He said that DHHS would try to keep the efforts regarding mental health on course and continue to build a strong base operation for the delivery of mental health services. The Secretary stated that he remains convinced that implementation of the Critical Assess Behavioral Health Agency (CABHA) model is the correct path toward a system that has a solid clinical base, focusing on outcomes and quality. He said that DHHS had been in discussion with the Center for Medicaid and Medicare Services (CMS) to allow a six month transition period in order for those organizations ready to become CABHAs by July 1 to begin operation, and allow others the opportunity to have additional time to meet the requirements to become a CABHA. Secretary Cansler added that DHHS has received over 500 letters from providers interested in becoming CABHAs and that DHHS had discussed the possibility of authorizing CABHAs to contract with small providers to provide certain services. He added that follow up conversations would continue next week. Finally, the Secretary reported that the Department continues to explore ways to receive input from consumers, families, local Consumer and Family Advisory Committees (CFACs) and the State Consumer and Family Advisory Committee (SCFAC).

Mike Watson, Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Services Development, DHHS, provided an update on the new category of provider agency, the Critical Access Behavior Health Agency (CABHA). (See Attachment No. 2) Mr. Watson briefly reminded members of CABHA implementation goals, basic service delivery requirements, the history leading to the development of the CABHA model, and then discussed the certification process and the planned efforts to monitor the CABHAs post-certification. His presentation addressed the following items:

- The CABHA model is a response to very serious past issues in our mental health system with respect to quality of services and medical oversight and is intended to restore confidence in the system.
- Vast majority of CABHA providers will be in the 50% FTE/8 hour certification requirement.
- Six hundred letters of attestation have been received for consideration of certification by July 1.
- There is concern with CMS and providers that there may be liability issues regarding providers subcontracting with CABHA.
- LMEs are working with providers who want to become CABHAs and working with providers who need endorsement for a second service.
- The cost of national accreditation for a large provider is approximately $80,000 and $5,000 - $10,000 for smaller agencies.
- The cost for the Medical Director working only 8 hours is built into the proposed case management rate giving the provider more flexibility in how to deliver other medication management services.
- It is estimated that CABHAs through quality care will generate savings of approximately $7M in total dollars and $2.5M - $3M in State dollars.

Some members expressed concern that the bar had been set too high for the small providers and that they were being forced out of business. There was also concern that only 13% of the 300 providers who had applied to become a CABHA had qualified and that CABHA did not address the issue of self-referral. There were several complaints by providers to LOC members regarding the application itself. Members requested a map or list of eligible CABHAs by LME in order to see the distribution. It was suggested that the Committee had the responsibility to work to see what could be done to boost the number of qualified providers in psychiatry and psychology; to look at schools and medical schools to increase the number of qualified professionals in the field to offer services, especially in the rural areas.

Dr. Craigan Gray, Director of the Division of Medical Assistance (DMA), along with Julian Mann, Director and Chief Administrative Law Judge, summarized the Medicaid recipient hearing appeals process. (See Attachment No. 3) Dr. Gray explained in detail the recipient right to a hearing after receipt of an advance notice of an adverse termination and noted the importance of the Mediation Network. Dr. Gray reviewed the successful changes to the process to implement the statutory standards. He said it was a very streamlined, time driven process which saved an estimated $25M over the review period. The effectiveness of the process is indicated by noting that 83% of the cases that

have come up for potential appeal have been resolved through mediation alone. He recommended that the appeals process continue.

Judge Mann recognized the coordination and cooperation of different agencies in developing a process that is working successfully. He credited mediation with giving those without representation an opportunity to have resolution and said this was accomplished within 25 days. Judge Mann said that in 2007, there were 2, 291 total cases; in 2008 there were 3,717 cases; and in 2009 there were 6,693 cases.

Senator Nesbitt reminded members that the appeals process was a recommendation from the LOC that was put into Session Law rather than the General Statutes, in order to try it for two years. This year, the Committee needs to determine whether to put it in Session Law for another two years or place it permanently in the General Statutes. It was suggested that OAH make information available on their website indicating how cases are settled and how cases are resolved that go to hearing. It was indicated that a large number of cases going to final decision are being reversed by DHHS. . Dr. Gray said he would get the actual figures on the number of overturned cases to Committee members.

Steve Owen, Chief Financial Operating Officer, DMA, provided an update on expenditures and utilization tracking for enhanced services. (See Attachment No. 4) The first page of graphs indicate recipients moving out of Community Support services and moving into Community Support Team. The number of recipients continues to rise but the expenditures have leveled out. Regarding Targeted Case Management, the rate reduction put in place in November dropped the expenditure level this year and there has been an increase in the number of recipients beyond the enrollment growth this year. Mr. Owen said that recipients moving out of Community Support were affecting Intensive In-Home with expenditures increasing about $8M more per month this year compared to last year. He said the combination of Community Support, Community Support Team, and Intensive In-Home services were about $10M a month less in total expenditures this year as compared to 2009.

Mike Watson, Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Services Development, DHHS, provided information on the 3 way contracts between DHHS, community hospitals and the LMEs. He explained that the contracts would expand Inpatient Psychiatric care (See Attachment No. 5) and provided the following information:

- In FY 09-10 there were 14,492 bed days delivered compared to 6,500 last year.
- Contract Summary chart – Cape Fear and Moses Cone have billings that have yet to be reflected on the chart and Western Highlands has twice as many bed days as what appears on the chart.
- Issue down the road – whether to continue to build on existing hospitals or add beds at new hospitals when they want to come online.
- As psychiatric beds are added to the community coupled with CABHA, it creates a demand for people with clinical skills which in turn encourages psychiatrists to move back into the scenario.

- There is concern from hospitals that have not expanded beds but do a significant amount of indigent inpatient psychiatric care. Data indicates indigent care has risen from 25% to 35%. Consumers with a substance abuse diagnosis are higher at 40% to 50%.
- Through contracting, Community hospitals are willing to get back into the inpatient psychiatric business and work with the State in accepting a more assertive role for short-term treatment of patients.

Leza Wainwright, Director of the Division on Mental Health, Developmental Disabilities and Substance Abuse Services, DHHS, explained the difference between the Psycho-Social Rehabilitation Centers (PSR) and Clubhouses. (See Attachment No. 6) She stated that the PSR program and the Clubhouses have the same main goals but the Clubhouses stress consumer ownership of the program. There are four LMEs that do not have at least one program that follows the clubhouse model: Cumberland, Eastpointe, Five County, and Onslow Carteret Behavioral Healthcare.

Ms. Wainwright was asked if the populations served by PSR, Clubhouses, or the International Center for Clubhouse Development (ICCD) was different and if there were any outcomes available. She responded that there was not a clinical profile on the individuals served in any of the 3 models. She also said that at this time, there were no noticeable differences in outcomes but North Carolina clubhouses and ICCD certified programs are billing Medicaid. They have to conform to the Medicaid service definition if they are going to bill Medicaid. Ms. Wainwright was also asked why Clubhouses, but not PSR's, are complaining that they are about to go out of business. She responded that the PSRs are also experiencing serious financial difficulty.

Next, Ms. Wainwright compared the CAP- MR/DD waiver, the PBH Innovations waiver and the new NC Innovations waiver (1915 b/c). (See Attachment No. 7) Ms. Wainwright explained the background of waivers and how they build off of the approved Medicaid State Plan. The Structure of Waivers chart depicts the current waivers: the CAP-MR/DD waiver, the way PBH operates now and what the proposal is for new participants coming into an expansion of the PBH waiver. PBH will make these same changes in their waiver at the time LMEs are added. She reviewed the criteria for participants and explained the differences in services. The final chart compared the financial components of the waivers. She informed LOC members that CMS would be doing a mid cycle review of the CAP-MR/DD waiver next week. She added that the chart did not include the fact that CMS requirements regarding consumer rights, protections, and appeals, apply to all the waivers also. One to two LMEs will be selected from those that have applied and will become operational January 2011.

Dr. John Gilmore, Director of the UNC Center for Excellence in Community Mental Health and Barbara Smith, Co-Director, explained how the Center came to be established and described the services they provide. (See Attachment No. 8) Ms. Smith reviewed the strong partnerships the Center has throughout the community. Besides treating those with severe mental illness, Dr. Gilmore provided insight into the different treatment programs offered such as STEP and OASIS. He said the Center and CCNC were in collaboration

regarding the integration of medical and psychiatric care. Dr. Gilmore said that the Center had been involved with many workgroups bringing their clinical expertise to help inform State policy. He described training and current research being conducted to improve the care of those with mental illness.

Dr. Patricia Porter, consultant to the LOC, explained that in support of and cooperation with DHHS in an effort to streamline reports, the leadership of the LOC directed a review of reports requested and submitted to the committee. (See Attachment No. 9) The purpose of the review was to ensure that reports continue to be submitted which are necessary to adequately provide oversight, to ensure that reports are in compliance with statutes and Session Laws and to eliminate outdated reportage. With the approval of the Committee, the recommendations will be made a part of the LOC report to the General Assembly.

Representative Insko advised that LOC members would receive a draft of the recommendations report for review. She requested that members contact staff with any changes to the report. The report will be reviewed at the next meeting on May 6th.

There being no further business, the meeting adjourned at 3:15 PM.

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Senator Martin Nesbitt, Co-Chair	Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant